No. 93-6404

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BAPTIST MEMORIAL HOSPITAL,
Plaintiff-Appellee,

v.

PAN AMERICAN LIFE INSURANCE COMPANY,
Defendant-Appellant,

MISSISSIPPI BANKERS' ASSOCIATION, Trustee of the Mississippi Bankers' Employees Benefit Plan and Trust,
Defendant,

MEMPHIS HOSPITAL SERVICE & SURGICAL ASSOCIATION, INC., d/b/a Blue Cross/Blue Shield of Memphis,
Defendant-Appellee.

ON APPEAL from the United States District Court for the Western District of Tennessee

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Decided and Filed February 1, 1995

Before: KENNEDY, MARTIN, and NELSON, Circuit Judges.

DAVID A. NELSON, Circuit Judge. Appellant Pan American Life Insurance Company provided hospitalization coverage to a man named Horace Thomas, a retired postal worker whose wife was employed as a bank manager. The Pan Am policy was issued to the Mississippi Bankers' Association, an employer group of which the bank where Mr. Thomas' wife worked was a member.

Appellee Memphis Hospital Service & Surgical Association, doing business as Blue Cross/Blue Shield of Memphis, provided hospitalization coverage to Mr. Thomas under an insurance contract (the "Service Benefit Plan") written by the Blue Cross and Blue Shield Association for the Federal Employees Health Benefit Program. Mr. Thomas was also enrolled in Medicare, a government health care program for the elderly.

On February 13, 1990, Mr. Thomas was injured in an automobile accident and was admitted to Baptist Memorial Hospital in Memphis, Tennessee. He remained in the hospital until November 16, 1990, by which time his hospital bill had risen to almost $600,000.

Mr. Thomas assigned his insurance benefits to the hospital on the day of his admission. A year or so later the hospital demanded payment under the Pan Am policy. Pan Am took the position that its contractual obligation to pay the claim was secondary to that of Blue Cross, because the Blue Cross plan covered Mr. Thomas directly and the Pan Am plan covered him only as a dependent. Blue Cross, for its part, took the position that Pan Am's obligation was primary. The hospital brought this lawsuit against the two insurance carriers to obtain a judicial determination as to which of them was the primary payer. Medicare was not joined as a party, and the record does not indicate that the hospital has ever demanded payment from Medicare.

As between Pan Am and Blue Cross, each insurance carrier's policy provides that the Blue Cross coverage is primary to the Pan Am coverage. If Medicare were involved, on the other hand, the Medicare coverage would be secondary to the Pan Am coverage but primary to the Blue Cross coverage. Under the "Medicare as Secondary Payer" statute, 42 U.S.C. § 1395y(b), Medicare cannot be required to pay ahead of Pan Am.

Do the provisions of the statute, and of the regulations adopted under it, abrogate contractual terms that specify who is to provide primary coverage as between Blue Cross and Pan Am? The district court evidently thought that this question should be answered in the affirmative; on cross-motions for summary judgment, the court entered judgment against Pan Am. It does not appear to us, however, that the statute and implementing regulations affect the contractual arrangements under which Pan Am's coverage is secondary to that of Blue Cross -- at least where no claim is being asserted against Medicare. We shall therefore reverse the district court's judgment.

I

Neither Pan Am nor Blue Cross disputes that it would be contractually bound to indemnify Mr. Thomas in the absence of other insurance. Pan Am, however, contends that it has not contracted to pay benefits that are the primary responsibility of another carrier -- and as between Pan Am and Blue Cross, Pan Am maintains, Mr. Thomas' hospital bill is the primary responsibility of Blue Cross.

The certificate of insurance that Mr. Thomas' wife received in connection with her employment at the bank supports Pan Am's contention. The certificate, which evidences the issuance of a group insurance policy by Pan Am to the Mississippi Banker's Association, contains a section captioned "CO-ORDINATION OF BENEFITS WITH OTHER HEALTH PLANS." The first paragraph of this section explains that

> "The purpose of group insurance is to help you to pay your medical bills. It is not intended that you receive more in benefits than the medical expenses you incur. Therefore, if you or your dependent are also covered under another 'plan' (as defined below) providing medical or dental benefits and the total benefits that you would receive would exceed the total 'allowable expenses' (as defined below), *the benefits under this Policy will be reduced so that no more than the total amount of 'allowable expenses' incurred by you or your dependent will be paid.*" (Emphasis supplied.)

After defining the terms "plan" and "allowable expense," Pan Am's certificate of insurance goes on to provide as follows:

> "When a claim is made the primary plan pays its benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the allowable expenses. No plan pays more than it would without the coordination provision.
>
> "A plan without a coordinating provision is always the primary plan. If all plans have such a provision: *(1) the plan covering the patient directly, rather than as an employee's dependent, is primary and the others secondary*, (2) if a child is covered under both parents' plans, the father's is primary, (3) if neither (1) nor (2) apply, the plan covering the patient longest is primary." (Emphasis supplied.)

The Blue Cross plan covers Mr. Thomas directly, rather than as an employee's dependent. If the Blue Cross plan has a coordinating provision, therefore, the italicized language in the last quoted paragraph means that the Blue Cross plan is primary and the Pan Am plan is secondary. (If the Blue Cross plan does not have a coordinating provision, the Blue Cross plan is primary by reason of the first sentence of the last quoted paragraph.)

The Blue Cross plan has not one coordinating provision, as it happens, but two. The first such provision, set forth under the caption "**General Limitations**" on page 7 of the 1990 edition of the brochure containing the Blue Cross contract, appears to cover coordination of benefits between Blue Cross and insurance carriers other than Medicare.[1] The second such provision, set forth at page 26 under the caption "**Service Benefit Plan and Medicare,**" spells out which plan is primary as between Blue Cross and Medicare.

We turn first to the provision on page 7 of the Blue Cross plan. Under the caption "**Coordination of Benefits,**" this provision offers an explanation not unlike the one found in the Pan Am certificate:

> "The Double Coverage provision is intended to prevent payment of benefits which exceed covered expenses. It applies when a person covered by this [Blue Cross] Plan also has, or is entitled to benefits as a result of, any other group health coverage . . . .

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[1] Under the subheading "**Double Coverage,**" the General Limitations section of the Blue Cross brochure says

> "The information in this Section is for subscribers who are not covered by Medicare. For information about coordination of benefits with Medicare, see page 26."

Because Mr. Thomas was covered by Medicare, it is perhaps arguable that the coordination of benefits provision on page 7 of the brochure has no application to him. If this provision does not apply, there being nothing else in the Blue Cross plan that purports to cover coordination of benefits with anyone other than Medicare, the Blue Cross coverage would be primary, as far as the Pan Am plan is concerned, because "[a] plan without a coordinating provision is always the primary plan." A more sensible reading of the Blue Cross brochure, we believe, is that the information on page 7 was intended to cover coordination of Blue Cross benefits with benefits under plans other than Medicare, while the information on page 26 was intended to cover coordination of Blue Cross benefits with those under Medicare.

* * *

"When there is double coverage, one plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount which, when added to the benefits payable by the other plan, will not exceed 100% of the usual, customary and reasonable charge for the service, but never more than would be payable in the absence of double coverage."

The key passage -- which is only one sentence long -- comes next:

"The determination of which plan is 'primary' (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners."

The NAIC guidelines are not quoted in the Blue Cross brochure, but are simply incorporated by reference.

The text of the guidelines said to have been in effect throughout the period of Mr. Thomas' hospitalization is contained in an attachment to the minutes of a meeting of the "Coordination of Benefits (B) Task Force" of the National Association of Insurance Commissioners held in Kansas City, Missouri on June 11, 1985.[2] The guidelines contain a model coordination of benefits provision for use

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[2]Copies of the minutes and their attachments have been placed in the record through an affidavit executed by John DeCantillon, a Pan Am employee. We do not know when the work of the task force was approved by the commissioners themselves, but Blue Cross has not challenged Mr. DeCantillion's sworn statement that these were the NAIC coordination of benefits guidelines in effect through the end of Mr. Thomas' hospitalization.

in group insurance contracts, and it is this provision that was incorporated by reference in the 1990 Blue Cross plan.

Under the caption "ORDER OF BENEFIT DETERMINATION RULES," the NAIC model contract provision says this, in relevant part:

> "This Plan determines its order of benefits using the first of the following rules which applies:
>
> "(i) *Non-Dependent/Dependent*. The benefits of the Plan which covers the person as an employee, member, or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent."

(Four other rules are then set forth, the last of which says that if none of the preceding rules applies, the plan that has covered the individual for the longer time comes before the plan that has covered him for the shorter time.)

The first rule -- the "Non-Dependent/Dependent" rule -- clearly applies here; the Blue Cross plan covered Mr. Thomas as a "subscriber," and the Pan Am plan covered him as a "dependent." As between Blue Cross and Pan Am, therefore, the rule provides that Blue Cross is to pay benefits first.

It sometimes happens, of course, that different contracts of insurance contain coordination of benefit provisions that are in conflict with one another. No such conflict is apparent here, at least when Medicare is not being asked to pay. As between Pan Am and Blue Cross, as we have seen, the Pan Am contract provides that Blue Cross is the primary payer because the Blue Cross plan is the one "covering the patient directly, rather than as an employee's dependent . . . ." The Blue Cross contract, similarly, provides that the obligation of Blue Cross comes first because the Blue Cross plan is the one that "covers the person as [a] . . . subscriber (that is, other than as a dependent) . . . ."

II

If Baptist Memorial Hospital were asserting a claim against Medicare, in addition to asserting claims against Pan Am and Blue Cross, we might have to resolve a possible conflict between the two coordinating provisions of the Blue Cross contract. While the first of these provisions puts benefits under the Blue Cross plan ahead of benefits under the Pan Am plan, the second puts Medicare benefits ahead of Blue Cross benefits -- and Medicare, by statute, comes behind Pan Am.

As between Blue Cross and *Medicare*, the Blue Cross brochure tells the subscriber at page 26 that "Medicare is Primary if [among other things] . . . [y]ou are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government." At the time of his hospitalization Mr. Thomas was an annuitant over age 65, he was covered by Medicare, and he was no longer employed by the federal government. Under the Blue Cross contract, therefore, Mr. Thomas' Medicare coverage was primary to his Blue Cross coverage.

Prior to 1981, the hospital's brief tells us, "Medicare coverage was *generally* primary to coverage under an employee health benefit plan." Brief of appellee Baptist Memorial Hospital, p. 6. (Emphasis supplied.)

> "As a cost-cutting measure, however, Congress eventually enacted a series of amendments designed to make Medicare a 'secondary' payer with respect to such plans. These amendments have been codified at 42 U.S.C. § 1395y(b), which is referred to as the 'Medicare as Secondary Payer' ('MSP') statute." *Health Ins. Ass'n of America v. Shalala*, 23 F.3d 412, 414 (D.C. Cir. 1994).

Under the caption "**Medicare secondary payer,**" 42 U.S.C. § 1395y(b)(2)(A) provides in general that "[p]ayment under [the Medicare] subchapter may not be made . . . to the extent that . . . payment has been made,

or can reasonably be expected to be made . . . as required under paragraph (1) . . . ." Paragraph (1), which is captioned "**Requirements of group health plans,**" provides in substance that "when someone age 65 or older is covered by an employer group health plan by reason of his current employment (or the current employment of his spouse), the plan may not 'take into account' that his age entitles him to Medicare benefits." *Health Ins. Ass'n of America*, 23 F.3d at 414, citing 42 U.S.C. § 1395y(b)(1)(A)(i)(I) (1993).[3]

The latter prohibition would affect Pan Am, under the circumstances of the present case, but not Blue Cross. Pan Am covered Mr. Thomas by reason of the current employment of his spouse, so Pan Am was precluded by law from making "the [Pan Am] plan's coverage secondary to Medicare's." *Id.* Blue Cross did not cover Mr. Thomas by reason of his current employment or the current employment of his spouse, so Blue Cross was permitted to make its coverage secondary to Medicare's -- and, as we have seen, it did precisely that at page 26 of its brochure.

III

What difference does the MSP statute make as far as priority of payment obligations between Blue Cross and Pan Am is concerned? None at all, in our view, on the facts presented here. In precluding Pan Am from making its coverage secondary to the coverage provided by

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[3] The text of § 1395y(b)(1)(A)(i)(I) is as follows:

"A group health plan --

> (I) may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(a) of this title . . . ."

Medicare, Congress did not purport to preclude either Pan Am or Blue Cross from making the Pan Am coverage secondary to the coverage provided by *Blue Cross*.

The MSP statute was passed in response to a dramatic increase in Medicare expenditures. By enacting the MSP provisions, "Congress sought to reduce Medicare spending and to insure the continued fiscal integrity of the Medicare program . . . ." *Provident Life and Accident Ins. Co. v. United States*, 740 F.Supp. 492, 495 (E.D. Tenn. 1990). Blue Cross argues that the payment of benefits under its plan, which insures active and retired federal employees, has a direct impact on the United States treasury because the Blue Cross plan is "experience rated" and the federal government pays approximately 60 percent of the cost of the program. The implication seems to be that by enacting the MSP provisions Congress sought not only to reduce Medicare spending but to reduce spending by Blue Cross as well.

The argument does not wash. There is no mention of the Federal Employees Health Benefits Program in the MSP statute. The statute relegates Medicare to the status of a "secondary payer" *vis-à-vis* a group health plan under which an individual is entitled to benefits by virtue of his current employment status (or that of his spouse), but the statute simply does not say that a Federal Health Benefits Program contractor such as Blue Cross is a secondary payer *vis-à-vis* an insurance carrier that provides coverage by virtue of someone's current employment status.

Neither do the regulations adopted under the MSP statute, 42 C.F.R. § 411.72, address the question of who must pay first as between two non-Medicare insurance plans. The regulations, as quoted by Blue Cross in its brief, provide as follows:

> (a) *Conditions the individual must meet.* Medicare Part A and Part B benefits are secondary to benefits

payable by an employer plan for services furnished during any month in which the individual --

(1) Is aged; . . .

(4) Meets one of the following conditions:

(i) is employed and covered, by reason of that employment, under an employer plan.

(ii) Is the aged spouse of an employed individual who -

(c) For services furnished after April 30, 1986 was, at the time the services were furnished, any age." (Emphasis by Blue Cross.)

As applied to the instant situation, this simply means that Medicare benefits are secondary to benefits payable under the insurance contract between Pan Am and the Mississippi Bankers' Association. The regulations are silent on the question whether Pan Am benefits are secondary to Blue Cross benefits or vice versa. That question is left to the contracts themselves -- and both contracts, as shown above, provide that the Pan Am benefits are secondary to the Blue Cross benefits.[4]

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[4]The opinion of the district court refers to a "Medicare Intermediaries Manual" in which the Health Care Financing Administration (the agency that administers the Medicare program) addresses the issue of Medicare liability where an individual covered by Medicare also has coverage under more than one employer group health plan. The manual stresses that private agreements "cannot supersede Federal law that makes Medicare secondary payer to certain [employer group plans];" therefore, the manual goes on to say, where an individual has private coverage based on current employment in addition to private coverage as a retiree, Medicare is secondary to the former coverage and primary to the latter "regardless of the coordination of benefits arrangements between the plans." It is clear

Contracts entered into subsequent to 1990 apparently contain different provisions. Through the affidavit of Robert Flohr, an employee of the Blue Cross and Blue Shield Association, Blue Cross has shown that the National Association of Insurance Commissioners changed its coordination of benefits rules in 1990[5] to carve out an exception to the "Non-Dependent/Dependent" rule. The exception provides that

> "If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is
>
> (a) Secondary to the plan covering the person as a dependent and
>
> (b) Primary to the plan covering the person as other than a dependent (e.g. a retired employee),
>
> then benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent."

By adding this exception, the NAIC resolved the circularity problem that would otherwise have existed where a claimant was seeking to recover hospital expenses both from Medicare and from more than one private insurance carrier.

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that the manual is concerned only with Medicare's liability and not with coordination of benefits provisions that do not purport to make Medicare the primary payer in violation of law. The manual even provides an illustrative example in which it says that "the retirement plan may choose to coordinate benefits with the employed spouse's [plan] so that the combined benefit of the two plans is primary to Medicare."

[5] The change was adopted in December, after Mr. Thomas' hospitalization had ended.

Even before adoption of the change by the NAIC, Mr. Flohr's affidavit says, Blue Cross and other insurers (not identified in the affidavit) "consistently coordinated benefits with other carriers based on the same order as was subsequently adopted by the NAIC." Obviously, however, a change in the terms of contracts entered into after Mr. Thomas' hospitalization cannot change the contracts that were in effect when the hospitalization occurred. Both of the two contracts in force when Mr. Thomas was hospitalized contained a "Non-Dependent/Dependent" rule, and neither contract recognized a Medicare exception to that rule. If Blue Cross and other insurers were coordinating benefits under their 1990 contracts as if such an exception had already been adopted -- which is what Blue Cross wants to do with Pan Am here -- such a practice cannot serve as a practical construction indicative of the intended meaning of the contracts with which we are concerned in this case absent a showing that Pan Am was coordinating benefits in the same way. No such showing has been made.

Blue Cross argues that what the contracts said in 1990 about coordination of benefits between Pan Am and Blue Cross had been made irrelevant by Congress. Congress had permitted Blue Cross to specify that the Blue Cross coverage would be secondary to Medicare's, the argument runs, and Blue Cross had done so. Congress had required that Medicare's coverage be secondary to Pan Am's, on the other hand, and had precluded Medicare from paying ahead of Pan Am. As a matter of Aristotelian logic, Blue Cross suggests, it follows that Congress had made the Blue Cross coverage secondary to the Pan Am coverage.

The argument does not persuade us. Medicare has no dog in this particular fight. Medicare has never been asked to pay anything, as far as we know, and has not been made a party to the lawsuit. Congress manifested no interest whatever in who would pay first as between private insurance carriers such as Pan Am and Blue Cross. The sole interest of Congress, as far as the statute discloses,

was to provide that Medicare would not have to pay ahead of private carriers in certain situations. Where that interest is not affected -- and it does not seem to be here -- we see no reason why the pertinent contractual provisions should not be enforced in accordance with their terms.

IV

Where a hospitalization plan that is primary to Medicare under the MSP statute fails to provide for primary payment in accordance with the statute, a private cause of action exists for damages "in an amount double the amount otherwise provided." 42 U.S.C. § 1395y(b)(3)(A). The district court applied this provision here, entering judgment for the hospital against Pan Am in an amount equal to twice the amount of the hospital expenses.

Because we conclude that Blue Cross was the primary payer as between itself and Pan Am, we need not decide whether Pan Am would be liable for double damages if it were the primary payer. As far as Blue Cross is concerned, it is liable for damages in the full amount it contracted to pay and no more. The double damage provision applies only in the case of a plan that is *primary* to Medicare, in accordance with 42 U.S.C. §§ 1395y(b)(1) and (2)(A), and Blue Cross is *secondary* to Medicare. Blue Cross clearly cannot be held liable for double damages.

The judgment of the district court is **REVERSED**, and the case is **REMANDED** to the district court for entry of judgment against Memphis Hospital Service & Surgical Association, Inc., d/b/a Blue Cross/Blue Shield of Memphis, in an amount not inconsistent with this opinion.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

No. 91-2919 4 BRO

BAPTIST MEMORIAL HOSPITAL,

Plaintiff,

vs.

PAN AMERICAN LIFE INSURANCE COMPANY and MEMPHIS HOSPITAL SERVICE & SURGICAL ASSOCIATION, INC., d/b/a BLUE CROSS/BLUE SHIELD OF MEMPHIS,

Defendants.

ORDER DENYING MOTION FOR SETTLEMENT CONFERENCE, GRANTING PARTIAL SUMMARY JUDGMENT TO PLAINTIFF, GRANTING CONDITIONAL SUMMARY JUDGMENT TO DEFENDANT BLUE CROSS, DENYING SUMMARY JUDGMENT TO DEFENDANT PAN AMERICAN, AND SETTING A STATUS CONFERENCE

[Filed (illeg.) D.C., 93 Jul 13 am11:41, (illeg.), Clerk ??? Dist. of,W.D. of Tn, Memphis (stamp)]

This is an action by a hospital for damages and declaratory judgment brought under the Medicare Act, 42 U.S.C. § 1395, for the payment of health insurance benefits. Before the Court are the following cross-motions: plaintiff Baptist Memorial Hospital's ("BMH") motion for

[This document entered on docket sheet in compliance with Rule 58 and/or 79(a) FRCP on 7/13/93.]

summary judgment; defendant Blue Cross's motion to dismiss and/or for summary judgment; and, defendant Pan American Life Insurance Company's ("Pan Am") motion for summary judgment. Prior to these motions, the Court will address a pending motion for a settlement conference filed by Pan Am.

FACTS

The basic facts are not in dispute. Horace A. Thomas ("Thomas") was injured in an automobile accident in February, 1990. He was hospitalized for treatment of his injuries at BMH in Memphis, Tennessee, on February 13, 1990. He was discharged on November 16, 1990. The total charges for hospital inpatient services were $579,842.29. Affidavit of David Calvin, Manager, BMH Patient Financial Services, 2. At the time of his admission, Thomas executed an assignment of all insurance benefits to BMH. BMH has not been paid on claims that it submitted to Pan Am and Blue Cross and sues to recover $569,530.29 in benefits, or an amount payable under the plan of the primary payer.[1] Pan Am and Blue Cross refused to pay because each one denies that it is the primary payer of benefits.

It is not disputed that Thomas was a beneficiary under three separate health insurance plans at the time of his hospitalization. First, Thomas was a retired employee of the United States Postal Service. As a retired federal employee, he was covered under a Blue Cross Service Benefit Plan, one of many plans offered through the Federal Employees' Health Benefit program. Second, he was covered as a dependent of an employed person under a group policy administered by Pan Am, a Louisiana insurance corporation, which had been obtained by

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[1] BMH arrived at this figure after crediting Thomas's account with $10,000.00 BMH received from an automobile liability insurer and application of a 55-Plus discount in the amount of $312.00.

his wife, Ann Thomas, through her employment at First State Bank in Olive Branch, Mississippi. Third, Thomas was over the age of 65 and was therefore eligible for Medicare benefits under Title XVIII of the Social Security Act, 42 U.S.C. § 1395, *et seq.*

The complaint is couched in alternative claims against Blue Cross and Pan Am. BMH seeks a declaratory judgment naming the primary payer; damages in the amount of primary benefits payable; plus interest at the effective rate of 12% per year pursuant to T.C.A. § 68-11-219; plus double damages as provided in 42 U.S.C. § 1395y(b)(3).[2]

The cross-motions address the issues of which defendant must be considered the primary payer, and whether double damages are available.

DISCUSSION

Motion For Settlement Conference

Pan Am has filed a written motion with accompanying memorandum for a settlement conference to be presided over by the Court. The Court has received letters in response to the motion from counsel for BMH and Blue Cross, bearing notations of copies sent to all counsel of record. Upon review of these papers, the Court concluded that the chances of a productive settlement conference prior to adjudication of the pending cross-motions for summary judgment were minimal. The Court will deny the motion without prejudice and proceed to rule on the cross-motions.

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[2] A third defendant, Mississippi Bankers' Association, allegedly Trustee of the employee benefit plan administered by Pan Am, was dismissed without prejudice from this case by Consent Order dated February 13, 1992.

Cross-Motions For Summary Judgment

The three motions raise the same two legal issues for the Court's decision: 1) whether defendant, Pan Am or Blue Cross, is legally obligated to be the primary payer of the hospital charges owed BMH; and, 2) whether plaintiff BMH is entitled to double damages under 42 U.S.C. § 1395y(b). The Court will discuss these issues in turn.

A movant is entitled to summary judgment only where there is no genuine issue as to any material fact and the moving party is entitled to summary judgment as a matter of law. F.R.C.P. 56(c). Summary judgment for the moving party is appropriate if the nonmoving party fails to make a sufficient showing on an essential element of its case on which it has the burden of proof. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). Blue Cross's motion requests dismissal and/or summary judgment. The Court does not find sufficient grounds for dismissal on the pleadings, thus it will treat the motion as one for summary judgment.

The "primary payer" issue is the core question in this suit. The parties agree, and the Court concurs, that the facts and law dictate that Medicare would not be the primary payer. Thus, with Medicare eliminated, the issue becomes the order of payment as between Blue Cross and Pan Am. Pan Am argues that Blue Cross is primary; Blue Cross argues that Pan Am is primary, Medicare is secondary, and Blue Cross is tertiary. BHM may have abandoned the alternative framework presented in its complaint for it expressly adopts and incorporates in its present motion the order of priority argued by Blue Cross.

The Court's analysis must start with the Medicare Act, 42 U.S.C. § 1395 *et seq.*, and regulations promulgated thereunder. The general rule until 1980, with an exception for workers' compensation payments not relevant here, was that if an individual who was entitled to

here, was that if an individual who was entitled to Medicare was also covered through an employer group health plan ("EGHP"), Medicare was the primary payer and the EGHP was the "secondary payer." *Blue Cross and Blue Shield Ass'n v. Sullivan*, 794 F. Supp. 1166, 1168 (D.D.C. 1992). As secondary payer, the EGHP paid expenses not covered by Medicare. In 1981, due to soaring costs in health care, Congress decided to reverse the order of payment under certain circumstances. The resulting legislation was the Medicare Secondary Payer Statute ("MSP statute"), *see*, 42 U.S.C. § 1395y. "The intent of this statute was to cut the costs of the Medicare program by requiring that Medicare pay "secondary" to alternate sources." *Id.* at 1169.

Read together, the following provisions of the MSP statute—42 U.S.C. § 1395y(b)(1) & (2)—have the effect of mandating that EGHP's are the primary payers for individuals who fall into a category known as the "working aged":

> (b) Medicare as secondary payer
>
> (1) Requirements of group health plans
>
> (A) Working aged under group health plans
>
> (i) In general
>
> A group health plan—
>
> (I) may not take into account, for any item or service furnished to an individual 65 years of age or older at the time the individual is covered under the plan by reason of the current employment of the individual (or the individual's spouse), that the individual is entitled to benefits under this title under section 42 U.S.C. § (a), and
>
> (II) shall provide that any employee age 65 or older, and any employee's spouse age 65 or older, shall be entitled to the same benefits under

> the Plan under the same conditions as any employee, and the spouse of such employee, under age 65.

42 U.S.C. § 1395y(b)(1).

Subsection (b)(2) provides:

> (2) Medicare secondary payer
>
> (A) In general
>
> Payment under this subchapter may not be made except as provided in subparagraph (B), with respect to any item or service to the extent that—
>
> (i) payment has been made, or can be reasonably be expected to be made, with respect to the item or service as required under paragraph (1), ...

Regulations implementing the MSP statute were promulgated by the Health Care Financing Administration ("HCFA"), an agency of the Department of Health and Human Services. The following regulations, found at 42 C.F.R. § 411.72, clarify the circumstances under which an EGHP is primary and Medicare secondary. Relevant portions are quoted:

> § 411.72 Medicare benefit secondary to employer group health plan benefits.
>
> (a) Conditions the individual must meet. Medicare Part A and Part B benefits are secondary to benefits payable by an employer plan for service furnished during any month in which the individual—
>
> . . .
>
> (4) Meets one of the following conditions:
> (i) Is employed and covered, by reason of that employment, under an employer plan.
> (ii) Is the aged spouse of an employed individual who—
>
> . . .

> (C) For services furnished after April 30, 1986 was, at the time the services were furnished, any age.

42 C.F.R. § 411.72 [54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990].

The operative subsections of the regulations for purposes of the present issue are (4)(i) and (ii). These subsections express in clear terms the conditions under which Medicare is secondary payer in relation to the EGHP. Of key relevance is subsection (4)(i) which requires that the individual be "employed and covered, by reason of that employment, under an employer plan." The Court construes this to mean that the individual must be covered through an EGHP from his own *current* employer. The Court notes that the "working aged" provision in the MSP statute itself applies the Medicare as secondary payer ruler only where the aged individual is covered under a group health plan "by reason of the *current employment* of the individual (or the individual's spouse) . . .". 42 U.S.C. § 1395y(b)(1)(I) (emphasis added). In this regard, absent from the criteria in the regulations is that of a retired individual who is a member of an EGBH by reason of *former* employment.

Where an individual is covered under Medicare and an EGHP that fails to qualify under the "working aged" provisions, the preexisting rule must apply under which Medicare is primary and the EGBH secondary. On these premises, therefore, where an EGBH covers a person by virtue of his status as a retired employee, Medicare would be the primary payer in relation to the EGBH.

No reported authorities exist on the issue of priority under these circumstances, but there is evidence that the implementing agency, HCFA, agrees with this interpretation. The HCFA has published a Medicare Intermediaries Manual distributed to Medicare carriers to assist them in coordinating benefits. The Manual states in

relevant part under Section 3491.6, which is sub-headed "Multiple Insurers":

> . . . (W)here the individual has EGHP coverage based on current employment in addition to EGHP coverage as a retiree, Medicare is secondary to the EGHP coverage based on current employment and primary to the EGHP coverage based on retirement regardless of the coordination of benefits arrangements between the plans.

Medicare Intermediaries Manual, dated 02-90, p. 4-593 (Blue Cross Supplemental Memorandum filed November 25, 1993, Ex. A).

To return to the case *sub judice,* it is the status of Thomas and his wife under each plan that determines the order in which the plans pay benefits. Thomas was covered under the Pan Am EGHP as the spouse of an active employee; he was covered as a subscriber of Blue Cross on the basis of his status as a retired federal employee; and, he was covered under Medicare. The coverage under Pan Am's EGHP must be primary. It satisfies one of the alternate criteria for a primary payer, namely, Thomas was the "aged spouse" (i.e., over 65) of an employed individual. 42 C.F.R. § 411.72(a)(4)(ii). The Blue Cross coverage, on the other hand, does not qualify under either of the criteria of the "working aged" provisions. Thomas was not currently employed by the Postal Service, and thus was not "employed and covered, by reason of that employment." 42 C.F.R. § 411.72 (a)(4)(i). Nor was the Blue Cross coverage obtained through his spouse's employment. Thus, Blue Cross is not required to be the primary payer, and becomes secondary payer to Medicare. The end result is that Pan Am is the primary payer, Medicare is the secondary payer, and Blue Cross is the tertiary payer.

The Court further finds that coordination of benefits provisions in the Blue Cross plan for 1990 express an

intention that it remain secondary to Medicare where the subscriber is a federal annuitant. See, FEHBP Service Benefit Plan 1990, 26.

Pan Am contends that provisions contained in its policy conflict with holding it to be primary payer. The federal law cited above supersedes conflicting provisions in a private insurer's plan.

Therefore, the Court finds that no genuine question of fact exists as to the order of payments, and that Pan Am is the primary payer as a matter of law. The Court will grant partial summary judgment to plaintiff BMH on its claims that Pan Am should be declared primary payer and should be held liable for payable benefits as primary payer. The Court grants partial summary judgment to Blue Cross on the primary payer issue, and will grant summary judgment in full to Blue Cross conditioned upon the absence of claims based upon tertiary liability. Finally, Pan Am will be denied summary judgment on the order of payments issue.

The Court now moves to the double damages issue. The MSP statute contains an enforcement provision, which states:

> (3) Enforcement
>
> (A) Private cause of action
>
> There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with such paragraphs (1) and (2)(A).

42 U.S.C. § 1395y(b)(3)(A).

Pan Am, joined by Blue Cross, argue that plaintiff is not entitled to double damages because the above provision creates a cause of action in the United States only.

This argument is meritless. The statute expressly creates a "private cause of action," which by definition is precisely the opposite from a governmental lawsuit on behalf of the general public. Furthermore, rights of action in the United States are already provided for in two other provisions of the MSP statute, one of which is headed "Action by United States." 42 U.S.C. § 1395y(2)(B)(ii) & (iii). The Court must follow the plain language of the controlling enforcement statute enacted by Congress. BMH was a private health care provider and assignee of rights to health insurance benefits, including those of Pan Am. By law, Pan Am was the primary payer of benefits. Pan Am failed to pay any benefits upon submission of BMH's claim. Therefore, Pan Am is liable for double damages.

The above rulings on liability and double damages, however, are not dispositive of the case. There remain at least two questions concerning the amount of damages. First, damages cannot be computed until the amount of benefits payable under the contractual terms of the Pan Am policy is determined. Pan Am's memorandum states that it has not yet made its own evaluation of what items on the hospital bill are payable under the policy. Second, BMH seeks to apply interest to the amount it is owed at the effective rate of 12% per year in reliance upon a Tennessee statute, T.C.A. § 68-11-219, which defines the payment rights and responsibilities of health care facilities which have submitted claims to insurers based upon assignment of benefits. The applicability of § 68-11-219 is not before the Court on the present motions.

STATUS CONFERENCE

The Court will hold a status conference with the attorneys in this case on Thursday, July 29, 1993, at 1:45 p.m. to discuss the status of damage claims and any other matters affecting the resolution of this case.

SUMMARY

Pan Am's motion for a settlement conference is DENIED without prejudice. BMH is GRANTED partial summary judgment on its claims for a declaratory judgment that Pan Am is primary payer of benefits, the liability of Pan Am as primary payer, and the liability of Pan Am for double damages under 42 U.S.C. § 1395y(b)(3)(A). Blue Cross is GRANTED conditional summary judgment conditioned upon the absence of a question of tertiary liability. The motion for summary judgment of Pan Am is DENIED.

IT IS SO ORDERED.

ENTER: This 13th day of July, 1993.

/s/ Robert M. McRae
ROBERT M. McRAE
SENIOR UNITED STATES DISTRICT JUDGE

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Case No: 93-6404

BAPTIST MEMORIAL HOSPITAL
Plaintiff - Appellee

v.

PAN AMERICAN LIFE INSURANCE COMPANY;
Defendant - Appellant

MISSISSIPPI BANKERS' ASSOCIATION, Trustee of the Mississippi Bankers' Employees Benefit Plan and Trust;
Defendant

MEMPHIS HOSPITAL SERVICE & SURGICAL ASSOCIATION, INC., doing business as Blue Cross/Blue Shield of Memphis
Defendant - Appellee

ORDER

[Filed, Mar 30, 1995, Leonard Green, Clerk (stamp)]

BEFORE: KENNEDY, MARTIN and NELSON, Circuit Judge

Upon consideration of the petitions for rehearing filed by the appellees, Memphis Hospital Service & Surgical Associations and Baptist Memorial Hospital.

It is ORDERED that the petitions for rehearing be, and they hereby are, DENIED.

ENTERED BY ORDER OF THE COURT

/s/ Leonard Green, jr
Leonard Green, Clerk

EXHIBIT 1
(Petition for Rehearing)

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Court of Appeals No. 93-6404

BAPTIST MEMORIAL HOSPITAL
Plaintiff-Appellee

v.

PAN AMERICAN LIFE INSURANCE CO.
Defendant-Appellant

MISSISSIPPI BANKERS' ASSOCIATION,
Trustee of the Mississippi Bankers'
Association Benefit Plan and Trust
Defendant

MEMPHIS HOSPITAL SERVICE & SURGICAL
ASSOCIATION, INC.
d/b/a BLUE CROSS/BLUE SHIELD OF MEMPHIS,
Defendant-Appellee.

AFFIDAVIT OF JUDY WHITE

STATE OF TENNESSEE
COUNTY OF SHELBY

Judy White, after being duly sworn, testifies and states as follows:

1. I am employed by Baptist Memorial Hospital (BMH) as the Director of Patient Financial Services, and I have personal knowledge of the account of Horace A. Thomas and the facts set forth in this affidavit.

2. Claims for benefits assigned to the hospital were submitted for all three coverages that Mr. Thomas had, including multiple claims to the fiscal intermediary for the Medicare Program which is Blue Cross/Blue Shield of Tennessee in Chattanooga, Tennessee.

3. Specifically, the records of the BMH Business Office show that Mr. Thomas was a patient in the hospital for over nine months, from February 14, 1990 through November 16, 1990. On June 22, 1990, while Mr. Thomas was still a patient in the hospital, BMH filed an interim claim for Medicare benefits for the period from February 14 through May 24, 1990. Medicare rejected the hospital's interim claim by incorrectly stating that the services were provided after the patient's date of death. Mr. Thomas was, of course, still alive and was still a patient in the hospital at this time. On December 6, 1990, Business Office personnel contacted the Medicare intermediary by telephone and spoke with "Angie" (no last name was given) who stated that she would "follow-up the claim to make sure there is not an error on Medicare's part," and she requested that the hospital please allow additional time to process the claim. It was subsequently determined that Medicare was not the primary payer.

4. On December 12, 1990, a claim was made to Mississippi Farm Bureau Insurance Company for primary liability insurance benefits, and in January 1991, BMH received liability insurance payments from the Farm Bureau for this claim.

5. A claim was then submitted to First State Bank of Mississippi for benefits under Mrs. Thomas's employee benefit plan through the Mississippi Bankers Association which was insured by Pan American Life Insurance Company.

6. On February 26, 1991, at the request of Pan American Life Insurance Company, BMH forwarded another claim by certified mail to First State Bank.

7. On March 20, 1991, Sharon Carter of the BMH Business Office spoke by telephone with John DeCantillon of Pan American Life Insurance Company. Mr. DeCantillon stated that Pan American was investigating to determine who was the primary carrier and also to verify that Mr. Thomas was covered under the policy. Ms. Carter advised Mr. DeCantillon that the group had already verified all this information. Mr. DeCantillon stated that "since Blue Cross is a federal policy, they are primary." Ms. Carter then called Blue Cross and spoke to Mary Hart who stated that once a patient becomes eligible for Medicare and the patient is retired, then Blue Cross reverts to a supplemental policy.

8. Ms. Carter again spoke with Mr. DeCantillon on March 21, 1991 at which time Mr. DeCantillon stated that Pan American was secondary because "they follow the gender rule." Mr. DeCantillon requested that the hospital file a claim with Blue Cross "to see what they would do", but Ms. Carter explained to him that Blue Cross would reject a claim without an explanation of benefits from Medicare. On that same day Ms. Carter spoke with Gloria Adams at Blue Cross who advised her to send the claim to her so that she could respond on Blue Cross letterhead stating that they were secondary to Medicare and that Ms. Carter could then send that letter to Pan American. She also stated that if that did not work, the hospital should file a claim with Medicare and instruct Medicare that Pan American was refusing to pay as primary carrier. Sharon Carter advised Mr. DeCantillon of the hospital's intention in this regard, but, according to Ms. Carter, he "didn't seem to care."

9. Hospital personnel had several telephone conversations with individuals at Blue Cross and Pan American regarding this account, including a telephone conversation with Mr. DeCantillon on May 17, 1991 in which Mr. DeCantillon apparently attempted to threaten or intimidate Sharon Carter by stating that the hospital "may be

setting itself up for liability" if it filed a claim for conditional payment with Medicare and told Medicare that Pan American was refusing to pay the claim.

10. On May 20, 1991, Cheryl Gibson of the BMH Business Office spoke by telephone with Lois Bailey, a provider representative with the Medicare intermediary in its Nashville office, who suggested that the hospital contact Virginia Rochelle in the Coordination of Benefits Department of the Medicare intermediary in Chattanooga. Ms. Rochelle stated that this was a good case for the hospital to file a conditional claim and she stated in order to submit such a claim the hospital should file a "hard copy" of the claim to her attention along with correspondence from Pan American and to advise Medicare of the name of the individual that the hospital had been dealing with at Pan American. On that same date, Cheryl Gibson contacted Ms. Green (no first name given) at the First State Bank who told her that Ann Thomas was a full time employee. Ms. Green also stated that on Friday, May 17, she was told that Pan American was "probably primary" but that they were "waiting on the lawyers to make up their minds." In addition, Ms. Green stated that "the insurance" (Pan American) had paid three rather large death claims recently.

11. On May 29, 1991, BMH submitted a request for a conditional payment to the Medicare intermediary along with a cover letter explaining the controversy with Pan American Life Insurance Company and Blue Cross. This letter was forwarded to the attention of Virginia Rochelle along with copies of correspondence from Pan American Life Insurance Company and Blue Cross.

12. On August 2, 1991, Virginia Rochelle advised by telephone conversation that she had not received the information, and on that same date, hospital personnel again forwarded the information to Ms. Rochelle.

13. On September 9, 1991, Virginia Rochelle of the Medicare intermediary called the hospital business office and requested that the hospital send back the claim along with the correspondence and she stated that she would ask for assistance from her regional office.

14. On June 5, 1992, Dawn Gentry, another employee of the Medicare intermediary, responded to a telephone inquiry from BMH's Business Office personnel requesting information as to the status of the hospital's claim for Medicare benefits. On June 11, 1992, business office personnel again spoke with Ms. Gentry who stated that the matter had been referred to Virginia Rochelle.

15. On February 9, 1993, BMH personnel attempted to contact Ms. Rochelle but she was out of the office. A subsequent call to the intermediary on the following day was routed to Mildred Dodd, the supervisor of claims for Medicare, who stated that she would follow the claim and who authorized the hospital to "re-key" the claim directly into the Medicare intermediary's computer system.

16. On March 22, 1993, Cheryl Gibson of the BMH Business Office contacted Connie Rowland at the Medicare intermediary. Ms. Rowland requested that the hospital send another letter to Medicare explaining the circumstances of this claim along with the names of the legal counsel in this case. She also directed the hospital to use certain coding procedures.

17. Another claim for Medicare benefits was prepared, and on April 13, 1993, BMH personnel again spoke by telephone with Virginia Rochelle and Medicare's legal counsel, Mary Eberle, regarding this account. Ms. Eberle and Ms. Rochelle advised the hospital that Medicare would not make a conditional payment when the primary payer refuses to pay.

18. BMH made several claims to Medicare including one claim for interim benefits while Horace Thomas was

still a patient in the hospital. BMH also submitted claims to Pan American Life Insurance Company and Blue Cross/Blue Shield of Memphis. In addition to submitting several claims to these carriers, BMH business office personnel had numerous telephone conversations with supervisory personnel for each of these carriers, including multiple discussions with the Medicare fiscal intermediary, Blue Cross/Blue Shield of Tennessee.

/s/ Judy White
Judy White
Director
Patient Financial Services
Baptist Memorial Hospital

SWORN TO AND SUBSCRIBED before me the undersigned Notary Public this 13th day of February, 1995.

/s/ Thomas L. McAllister
Notary Public

My Commission expires July 12, 1998

CERTIFICATE OF SERVICE

A copy of the foregoing was mailed, postage prepaid, to Mr. Albert T. McRae, 2 Washington Courtyard, 295 Washington Avenue, Memphis, TN 38173, and to Ms. Rita Theisen and Michael F. McBride, LeBOEUF, LAMB, GREENE & McRAE, 1875 Connecticut Ave, N.W., Suite 1200, Washington, D.C. 20009, attorneys for defendant-appellant Pan American Life Insurance Company, and Mr. John I. Houseal, Jr., and Mr. William L. Bomar, GLANKLER, BROWN, One Commerce Square, Suite 1700, Memphis, TN 38103, attorneys for defendant-appellee Memphis Hospital Service and Surgical Association, Inc., d/b/a/ Blue Cross/Blue Shield of Memphis, this ___ day of _____, 1995.

MEDICARE AS SECONDARY PAYER

42 U.S.C. § 1395y(b)

(b) Medicare as secondary payer

(1) Requirements of group health plans

(A) Working aged under group health plans

(i) In general

A group health plan—

(I) may not take into account, for any item or service furnished to an individual 65 years of age or older at the time the individual is covered under the plan by reason of the current employment of the individual (or the individual's spouse), that the individual is entitled to benefits under this subchapter under section 426(a) of this title, and

(II) shall provide that any employee age 65 or older, and any employee's spouse age 65 or older, shall be entitled to the same benefits under the plan under the same conditions as any employee, and the spouse of such employee, under age 65.

(ii) Exclusion of group health plan of a small employer

Clause (i) shall not apply to a group health plan unless the plan is sponsored by or contributed to by an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(iii) Exception for small employers in multiemployer or multiple employer group health plans

Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multi-

ple employer group health plan if the coverage of the individuals under the plan is by virtue of employment with an employer that does not have 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

(iv) Exception for individuals with end stage renal disease

Clause (i) shall not apply to an item or service furnished in a month to an individual if for the month the individual is, or would upon application be, entitled to benefits under section 426–1 of this title.

(v) "Group health plan" defined

In this subparagraph, and subparagraph (C), the term "group health plan" has the same meaning given such term in section 5000(b)(1) of Title 26.

(B) Disabled active individuals in large group health plans

(i) In general

A large group health plan (as defined in clause (iv)(II)) may not take into account that an active individual (as defined in clause (iv)(I)) is entitled to benefits under this subchapter under section 426(b) of this title.

(ii) Exception for individuals with end stage renal disease

Clause (i) shall not apply to an item or service furnished in a month to an individual if for the month the individual is, or would upon applica-

tion be, entitled to benefits under section 426–1 of this title.

(iii) Sunset

Clause (i) shall only apply to items and services furnished on or after January 1, 1987, and before October 1, 1995.

(iv) Definitions

In this subparagraph:

(I) Active individual

The term "active individual" means an employee (as may be defined in regulations), the employer, self-employed individual (such as the employer), an individual associated with the employer in a business relationship, or a member of the family of any of such persons.

(II) Large group health plan

The term "large group health plan" has the meaning given such term in section 5000(b)(2 of Title 26.

(C) Individuals with end stage renal disease

A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is entitled to benefits under this subchapter solely by reason of section 426–1 of this title during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 426–1 of this title, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under provisions of section 426–1 of this

title if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from taking into account that an individual is entitled to benefits under this subchapter solely by reason of section 426–1 of this title after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and on or before January 1, 1996,[2] (with respect to periods beginning on or after February 1, 1990), clauses (i) and (ii) shall be applied by substituting "18-month" for "12-month" each place it appears.

(D) Treatment of certain members of religious orders

In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of Title 26.

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item to the extent that—

(i) payment has been made, or can be reasonably be expected to be made, with respect to

the item or service as required under paragraph (1), or

(ii) payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies.

(B) Conditional payment

(i) Primary plans

Any payment under this subchapter with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this subchapter when notice or other information is received that payment for such item or service has been or could be made under such subparagraph.

(ii) Action by United States

In order to recover payment under this subchapter for such an item or service, the United States may bring an action against any entity which is required or responsible under this subsection to pay with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph

plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service.

(iii) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(iv) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interest of the program established under this subchapter.

(3) Enforcement

(A) Private cause of action

There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with such paragraphs (1) (2)(A).

(B) Reference to excise tax with respect to nonconforming group health plans

For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of Title 26.

(C) Prohibition of financial incentives not to enroll in a group health plan

It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this subchapter not to enroll (or to terminate enrollment) under a group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)), unless such incentive is also offered to all individuals who are eligible for coverage under the plan. Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1320a-7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(4) Coordination of benefits

Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this subchapter (without regard to deductibles and coinsurance under this subchapter) for the remainder of such charge, but—

(A) payment under this subchapter may not exceed an amount which would be payable under this subchapter for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this subchapter, when combined with the amount payable under the primary plan, may not exceed—

(i) in the case of an item or service payment for which is determined under this subchapter on the basis of reasonable cost (or other cost-related basis) or under section 1395ww of this title, the amount which would be payable under this subchapter on such basis, and

(ii) in the case of an item or service for which payment is authorized under this subchapter on another basis—

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this subchapter (without regard to deductibles and coinsurance under this subchapter),

whichever is greater.

(5) Identification of secondary payer situations

(A) Requesting matching information

(i) Commissioner of Social Security

The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(*l*)(12) of Title 26) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) Administrator

The Administrator of the Health Care Financing Administration shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the

Administrator the information described in subparagraph (B) of section 6103(*l*)(12) of Title 26.

(B) Disclosure to fiscal intermediaries and carriers

In addition to any other information provided under this subchapter to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for the purposes of carrying out this subsection.

(C) Contacting employers

(i) In general

With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of Title 26 by a qualified employer (as defined in section 6103(*l*)(12)(D)(iii) of such title), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) Employer response

Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly

fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(iii) Sunset on requirement

Clause (ii) shall not apply to inquiries made after September 30, 1995.

(c) Drug products

No payment may be made under part B of this subchapter for any expenses incurred for—

(1) a drug product—

(A) which is described in section 107(c)(3) of the Drug Amendments of 1962,

(B) which may be dispensed only upon prescription,

HCFA'S WORKING AGED REGULATION

42 C.F.R. § 411.72

§ 411.72 Medicare benefit secondary to employer group health plan benefits.

(a) *Conditions the individual must meet.* Medicare Part A and Part B benefits are secondary to benefits payable by an employer plan for services furnished during any month in which the individual—

(1) Is aged:

(2) Is entitled to Medicare Part A benefits under § 406.10 of this chapter;

(3) Is not entitled, and could not upon filing an application become entitled, to Medicare on the basis of end-stage renal disease as provided in § 406.13 of this chapter; and

(4) Meets one of the following conditions:

(i) Is employed and covered, by reason of that employment, under an employer plan.

(ii) Is the aged spouse [3] of an employed individual who—

(A) For services furnished before January 1985 was, at the time the services were furnished, age 65 through 69;

(B) For services furnished from January 1, 1985 through April 30, 1986 was, at the time the services were furnished, any age through 69; or

(C) For services furnished after April 30, 1986 was, at the time the services were furnished, any age.

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[3] A spouse may be entitled to Medicare Part A benefits on the basis of the employed individual's earnings record, or the spouse's own earnings record. [54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990]

(b) *Exception for multiemployer plans.* If a multiemployer plan can identify particular enrollees as employees of an employer of fewer than 20 employees, Medicare is primary for those enrollees and their spouses.

(c) *Refusal to accept employer plan coverage.* An employee or spouse may refuse the health plan offered by the employer. If the employee or spouse refuses the plan—

(1) Medicare is primary payer for that individual; and

(2) The plan may not offer that individual coverage complementary to Medicare.

(d) *Coverage of reemployed retiree or annuitant.* A reemployed retiree or annuitant who is covered by an employer group health plan is considered covered "by reason of employment" if the employer provides the same group coverage to retirees as to other employees in the same category. This rule applies even if—

(1) The plan is the same plan that previously provided coverage to that individual when he was a retiree or annuitant; or

(2) The premiums for the plan are paid from a retirement pension or fund.

(e) *Secondary payments.* Medicare pays secondary benefits, within the limitations specified in §§ 411.32 and 411.33, to supplement the primary benefits paid by the employer plan if that plan pays only a portion of the charge for the services.

(f) *Disabled aged individuals who are considered employed.* (1) For services furnished on or after November 12, 1985, and before July 17, 1987, a disabled, nonworking individual age 65 or older was considered employed if he or she—

(i) Was receiving, from an employer, disability payments that were subject to tax under the Federal Insurance contributions Act (FICA); and

(ii) For the month before the month of attainment of age 65, was not entitled to disability benefits under title II of the Act and 20 CFR 404.315 of the SSA regulations.

(2) For services furnished on or after July 17, 1987, an individual is considered employed if he or she receives, from an employer, disability benefits that are subject to tax under FICA, even if he or she was entitled to Social Security disability benefits before attaining age 65.